REQUEST FOR DIRECTED RESEARCH COURSE

1435 N. Glenstone Avenue ◆ Springfield, MO 65802
1-800-467-2487 ◆ 417-268-1000 ◆ 417-268-1030 FAX ◆ www.agts.edu

Return form with required 1/3 partial or full payment to Registrar's Office

NAME_______________________________ SOCIAL SECURITY NUMBER_______________________________

ADDRESS____
Street/Box *City* *State* *Zip*

TELEPHONE (______)_______________________ E-MAIL____________________ FAX____________________

DO YOU CURRENTLY HAVE ANY OTHER DR COURSES OUTSTANDING? ❑ YES ❑ NO

IF YES, NAME OF COURSE____

INTENDED DATE OF COMPLETION____

COURSE INFORMATION: *(List specific DR course to be pursued)*

COURSE TITLE____

CREDIT HOURS_______________ SEMESTER OF ENROLLMENT___________________________________

REASON FOR REQUEST:

____

____

RECOMMENDED PROFESSOR OF RECORD: *(To be completed by student)* ______________________________
IS THERE AN EXISTING ISP COURSE THAT COULD BE ASSIGNED? ❑ YES ❑ NO

SIGNATURES REQUIRED:

STUDENT____ DATE____________________

ADVISOR____ DATE____________________

ACADEMIC DEAN_______________________________________ DATE____________________

For Office Use Only

Deposit Rec'd:____________________ Presession Work: ________________
(if applicable)

Registration: ____________________

Degree Program: __________________ Hours Completed to Date: __________

Total Directed Research Hours Completed to Date: ____________________________

Placement on Degree Program: ____

Instructor Assigned (*By Academic Dean):* __________________________________